

number of women members. As late as 1991, 28 per cent of research ethics committees in the UK (who responded to the questionnaire sent out by the King's Fund Institute) had fewer than 20 per cent female membership and only seven per cent of the committees had equal numbers of women – or a female majority (3). It is in the institutions governing research, and in the way that decisions are made, that the problems lie – and the discrimination is not conscious.

Sherwin, Holmes and Purdy have produced excellent, thought-provoking volumes. What is lacking as yet is a programme for action, but action is impossible without the analysis, which they and their colleagues have provided. We may not agree with everything. But there is enough material here for all of us to be brought up short, and think that a feminist analysis of medicine and medical training is long overdue.

## References

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## Choices in health care

Government Committee on Choices in Health Care, the Netherlands, Zoetermeer, Ministry of Welfare, Health and Cultural Affairs, 1992, 160 pages, free.

This Dutch report ought to be required reading for anyone who is interested in health care rationing. It was produced by a committee chaired by Professor Dunning, a cardiologist, in response to a formal request from the government, and is intended as the start of a public discussion. The

report, which is available in English, also provided the focus for a resolution of the Council of Ministers of the EEC, during the Netherlands presidency, calling for some collective co-operation within the community to enable national governments to make better choices. Quite where that European initiative will go must be uncertain until it becomes clear post-Maastricht what the content and limits of the European Union's health competence are to be.

The Dunning committee's approach is first to assert that choices are necessary, and will become more so, because scientific and technological advance will generate treatment possibilities faster than our capacity to pay for them. They suggest that there should be a basic package of care, financed collectively, which should comprise only services that meet four criteria. The committee presents these criteria as a series of sieves, each retaining some services that will therefore fail to qualify for the basic package. The four criteria are:

1. From a community viewpoint, is this service necessary in the sense, for example, that it guarantees normal function as a member of the community? Examples include continuing tender loving care for people for whom cure is out of the question, such as the elderly confused and (using Dutch terminology) people who are mentally handicapped.
2. Is this service effective, and is effectiveness confirmed and documented?
3. Is this service efficient, using cost-effectiveness and cost-utility analyses?
4. Is this something that cannot properly be left to individual responsibility?

The idea of the sieves is graphic and conceptually helpful. Personally, I find the first sieve the least clear conceptually. I can understand a sense in which immunisation is communally necessary, but not one in which (apparently) all nursing home care is equally necessary. On the other hand, I was encouraged to hear a member of the committee say that when care had to be rationed the Dutch would ration acute care but not humane care for people with chronic illness. Overall, however, the notion of communally necessary care seems much less clear in the committee's thinking than the other three criteria.

A problem that the Dutch (along with everyone else) will face is that general principles are one thing,

specific exclusions are another. In New Zealand there is a national committee at work trying to define core services. Surprise, surprise, it looks as though the core may turn out to be roughly equivalent to the range of services currently financed by the state. Similarly in the UK, once people have proposed the exclusion of tattoo removals and cosmetic surgery, the going quickly becomes rough.

One of the strengths of the Dunning report, however, is that it does take a number of examples of specific services (IVF, homoeopathic medicines, dental care for adults, sports injuries, homes for the elderly) and discusses whether they qualify for inclusion in the core. In the committee's opinion, IVF, homoeopathic medicines and adult dental care do not qualify; sports injuries and homes for the elderly do. Whether or not one is convinced, the book deserves to be widely read. It provides an alternative to Oregon in the staple rationing diet.

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## Talking with patients: a basic clinical skill

Philip R Myerscough, Oxford, OUP,  
1992, 200 pages, £12.95 sc.

Students often regard talking with patients as 'commonsense' and may resent teaching which they perceive as belittling. Yet there is ample evidence that the communication skills of young doctors are often seriously deficient. This discrepancy between a student's opinion of his or her skills and reality poses a major obstacle to teaching. Overcoming this requires skill and tact.

*Talking with Patients* falls at this obstacle for two reasons. It is very superficial, dealing with a huge range of subjects in 200 pages with only brief mention of important aspects of relating to patients such as non-verbal communication. More seriously, much of the book is devoted to the data-gathering of traditional history-taking, which is doctor and disease-oriented rather than concerned with the patient and his problem. In this the author appears as a new and sometimes reluctant convert to communication skills.